Initial Approval: April 12, 2017

CRITERIA FOR PRIOR AUTHORIZATION

Emflaza™ (deflazacort)

PROVIDER GROUP Pharmacy

MANUAL GUIDELINES The following drug requires prior authorization:
Deflazacort (Emflaza™)

CRITERIA FOR APPROVAL (must meet all of the following):

- Diagnosis of Duchenne muscular dystrophy (DMD)
- Must be prescribed by or in consultation with a pediatric neurologist
- Patient must be 5 years of age or older

LENGTH OF APPROVAL: 12 months

_____
DRUG UTILIZATION REVIEW COMMITTEE CHAIR

_____
DATE

_____
PHARMACY PROGRAM MANAGER
DIVISION OF HEALTH CARE FINANCE
KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

_____
DATE